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January 31, 2020

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health & Human Services

VIA ELECTRONIC SUBMISSION

RE: CMS-2393-P – Proposed Rule – Medicaid Program; Medicaid Fiscal Accountability Regulation

Dear Ms. Verma:

LeadingAge Wyoming ("LAW") represents 22 long-term care providers, 14 of which are Non-State Government Owned ("NSGO") Skilled Nursing Facilities ("SNF") that participate in the State of Wyoming's Skilled Nursing Facility Upper Payment Limit Program ("UPL Program"). These comments are provided on behalf of the 14 NSGO-SNFs currently in the UPL Program and other SNFs that may join the UPL Program.

The UPL Program has spurred dramatic improvements in the quality of care and facilities that the NSGO-SNFs are able to provide to Medicaid beneficiaries over the past few years since the UPL Program was approved by CMS and implemented in Wyoming, under the direction of Wyoming Medicaid. Facilities have been updated, Star Ratings have improved, nursing ratios have risen, resident programs and enrichment opportunities have increased, and the overall care of Medicaid patients has improved.

LAW is concerned that the important and significant advancements in quality of care and facility infrastructure that is occurring in Wyoming as a result of the UPL Program will be destroyed if the changes proposed in the Medicaid Fiscal Accountability Rule (the "Proposed Rule") are adopted. As currently drafted, the Proposed Rule may have a crippling effect on the UPL Program. Without the additional revenue that SNFs receive under the UPL Program for the services they furnished to Medicaid beneficiaries, these SNFs may not be able to sustain the quality improvements achieved through UPL Program participation.

In addition to the UPL Program, there is a significant potential for the state's other supplemental payment programs to be undermined which will adversely affect those who rely on the Medicaid program for care across the state of Wyoming. The magnitude of financial loss to the Medicaid program as a result of this rule, the restriction of access to important financing and limiting supplemental payments, will decrease the quality of care and reduce access to care for our state's most vulnerable patients. Nursing homes and rural hospitals are likely to be impacted in a negative way.

LAW strongly urges CMS to withdraw or significantly modify the Proposed Rule to ensure that it does not compromise access to high-quality nursing facility services for thousands of Medicaid patients and residents in Wyoming and throughout the United States. The enclosed detailed comments set forth many of the legal arguments as to why the Proposed Rule is inconsistent with CMS authority and Congressional intent. To summarize the practical impact of a few of the major changes, please consider the following comments:

IGT Payments

While most of my NSGO members participating in the UPL Program receive a small amount of tax revenue from the district or county that created them, they operate substantially from operational and patient revenue. These NSGOs makes IGT payments to Wyoming Medicaid to contribute towards funding for the UPL Program using funds from tax revenue, operational and patient revenue and savings. CMS's proposed requirement that all IGT payments must be made from state or local taxes is inconsistent with federal law and may make it difficult for these NSGOs to contribute IGT payments for the UPL Program from only tax revenue. As such, this proposed change could create a significant challenge for the UPL Program and the NSGOs' participation. CMS must rescind the Proposed Rule or modify it to allow my NSGO members and other NSGOs to use other sources of revenue for IGTs, including, but not limited to, operational revenue, patient revenue and bank financing.

Definition of Non-State Government Provider – NSGO

Like the MFAR requirement that IGT payments be made from state or local taxes, part of the new definition of NSGO requires the NSGO to have access to and exercise administrative control over local tax revenue. This requirement, and the proposed "totality of circumstances" test for determining whether a provider is an NSGO are vague and contrary to law. Such proposed changes would potentially allow CMS to determine that a government owned provider, created by a county or district, is not an NSGO – a patently ridiculous outcome that is outside of CMS's administrative authority.

SPA Sunset Rule

As stated in more detail below, CMS does not have the authority to terminate the State Plan Amendment that created the UPL Program. Even if CMS had such power, the proposed

two-year window leaves my member NSGOs, the SNF industry, and particularly Medicaid and the state legislature insufficient time to phase out and/or create a suitable solution or strategy. As such, the Sunset rule should be removed.

For these, and the reasons set forth below, LAW requests the Proposed Rule be withdrawn in its entirety or significantly modified. We appreciate your consideration of these comments. We look forward to working with the agency to promote transparency and accountability in Medicaid payment policies.

Sincerely,

Eric Boley
President
LeadingAge Wyoming

LEADINGAGE WYOMING
DETAILED COMMENTS ON PROPOSED
MEDICAID FISCAL ACCOUNTABILITY RULE

STATE SHARE OF FINANCIAL PARTICIPATION

CMS proposes to amend its regulations at § 433.51 based on an unreasonable interpretation of § 1903(w)(6) and without regard for its obligation to consult with the States. In addition, the phrase "unallowable sources" at § 433.51(d) is unclear and could lead to administrative action that is in direct conflict with statute.

Tax Revenues Are Not The Only Allowable Source of Funds for IGTs. CMS proposes to amend § 433.51 to set forth a more detailed specification of the funds that may be used as the non-Federal share of Medicaid expenditures. In particular, CMS proposes at § 433.51(b)(2) that an IGT of funds from a unit of government within a State must be derived from State or local taxes (or funds appropriated to State university teaching hospitals) (the "Tax Revenue Requirement"). CMS states that the proposed changes would "more closely align with the provisions in section 1903(w) of the Act" and make it "abundantly clear that, as indicated in the statute, the IGT must come from state or local tax revenue…." LeadingAge Wyoming is concerned about CMS's unreasonably narrow interpretation of the funds from local sources that may be used to finance the non-Federal share of Medicaid program expenses. As discussed below, proposed § 433.51(b)(2) represents an interpretation of § 1903(w)(6) that is inconsistent with the language and structure of Title XIX and the legislative history of § 1903(w), in particular.

"[I]t is a fundamental canon of statutory construction that the words of a statute must be read in their context and with a view to their place in the overall statutory scheme."[1] CMS regulations at Part 433, Subpart B implement Sections 1902(a)(2), 1903(a), and 1903(w) of the Act.[2] Section 1902(a)(2) requires a State plan to provide for financial participation by the State towards the cost of its Medicaid program and allows the State to use "funds from local sources" in order to meet this obligation, as long as doing so does not compromise equal access to services within the State. Section 1903(a) requires the Federal government to pay each State an amount of Federal financial participation ("FFP") based on the State's expenditures under its State plan. Section 1903(w) requires that, for purposes of calculating the FFP due to a State under § 1903(a), the State's expenditures must be reduced by any amounts received by the State or a unit of local government within the State from certain provider-related donations and health care-related taxes. In this way, § 1902(a)(2) and § 1903(w) operate in relation to one another: § 1902(a)(2) makes

[1] National Ass'n of Home Builders v. Defenders of Wildlife, 551 U.S. 644, 666 (2007) (internal quotations omitted) (quoting FDA v. Brown & Williamson Tobacco Corp., 52 U.S. 120, 132 (2000)).
[2] 42 C.F.R. § 433.50(a).

FFP available for expenditures financed using "funds from local sources" and § 1903(w) makes FFP unavailable for expenditures financed using funds obtained by a State or unit of local government through certain mechanisms.

The Tax Revenue Requirement is not a permissible interpretation of § 1903(w)(6)(A) because it fails to reasonably account for the relationship between § 1903(w)(6)(A) and § 1902(a)(2). Section 1903(w)(6)(A) states:

> "*Notwithstanding the provisions of this subsection*, the Secretary may not restrict States' use of funds *where such funds are derived from State or local taxes*… transferred from… units of government within a State…, regardless of whether the unit of government is also a health care provider, except as provided in section 1902(a)(2), unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share under this section."[3]

The principle that a statute must be interpreted "as a symmetrical and coherent regulatory scheme," and "fit, if possible, all parts into an harmonious whole"[4] leads to the conclusion that funds derived from State or local taxes transferred from units of government within a State ("Unrestrictable Funds") are also "funds from local sources" authorized as State financial participation under § 1902(a)(2). The Tax Revenue Requirement is *ultra vires* because it requires that the inverse of this conclusion is also true: "funds from local sources" authorized as State financial participation under § 1902(a)(2) are also Unrestrictable Funds.[5] This latter conclusion, on which the Tax Revenue Requirement relies, is unsupported by the statutory text and legislative history.

"A cardinal doctrine of statutory interpretation is the presumption that Congress's use of different terms within related statutes generally implies that different meanings were intended."[6] Indeed, the ordinary meaning of "source" is not specific to taxes.[7] As CMS itself has observed: "units of government collect revenue from a variety of sources (including fees, grants, earned interest, fines, sale or lease of public resources, legal settlements and judgments, revenue from bond issuances…."), etc.[8] Had Congress intended to authorize only local tax revenues to be used

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[3] Emphasis added.
[4] *See* Food & Drug Admin. v. Brown & Williamson Tobacco Corp., 529 U.S. 120, 133 (2000) (quoting Gustafson v. Alloyd Co., 513 U.S. 561, 569 (1995) and FTC v. Mandel Brothers, Inc. 359 U.S. 385, 389 (1959)).
[5] To illustrate using an analogy: the conclusion that all squares are rectangles does not necessarily mean that all rectangles are squares.
[6] Res-Care, Inc. v. U.S., 735 F.3d 1384, 1389 (2013) (internal quotations omitted).
[7] Merriam-Webster defines "source" as "a generative force" and "a point of origin or procurement." Sources (plural) therefore means multiple generative forces or points of origin or procurement.
[8] CMS, Medicaid Program, Cost Limit for Providers Operated by Units of Government, 72 Fed. Reg. 29747, 29766 (May 29, 2007) (Rescinded).

in addition to State funds as financing for the non-Federal share of expenditures, "it knew how to use those words and could have done so. It did not."[9]

Moreover, there is no basis on which to infer that, in adopting § 1903(w)(6)(A), Congress intended to repeal the ordinary meaning of "funds from local sources" and replace it with Unrestrictable Funds. "While a later enacted statute… can sometimes operate to amend or even repeal an earlier statutory provision…, repeals by implication are not favored and will not be presumed unless the intention of the legislature to repeal is clear and manifest."[10] A statutory repeal will not be inferred "unless the later statute expressly contradicts the original act or unless such a construction is absolutely necessary in order that the words of the later statute shall have any meaning at all."[11] To the contrary, interpreting § 1903(w)(6)(A) as effectively redefining "funds from local sources" to mean Unrestrictable Funds renders significant portions of § 1903(w) superfluous or redundant.

For example, if Congress intended Unrestrictable Funds to be the only "funds from local sources" authorized for use as State financial participation under § 1902(a)(2), the use of any local funds not derived from tax revenue would necessarily be ineligible for FFP, since FFP is always limited to expenditures consistent with a State plan. It would therefore be superfluous for Congress to have added the language at § 1903(w)(1)(A) prohibiting FFP for "any revenues received… by a unit of local government in the State… from provider-related donations…, other than… bona fide provider-related donations… and [certain other] donations," because such funds would not have been eligible for FFP in the first place. Only by interpreting the meaning of "funds from local sources" as broader than Unrestrictable Funds is it possible to give meaning to all of Congress's words at § 1903(w).

The legislative history of § 1903(w) also supports an interpretation of "funds from local sources" as encompassing more than Unrestrictable Funds. Section 1903(w) was adopted into the Social Security Act by the Medicaid Voluntary Contribution and Provider-Specific Amendments of 1991 (the "Amendments").[12] At Section 5(a) of the Amendments, Congress delegated to CMS the authority, *subject to subsection (b),* to issue regulations as necessary to implement the Amendments and its changes to the Act. Section 5(b) of the Amendments states:

> "The Secretary [of HHS] may not issue any interim final regulation that changes the treatment *(specified in section 433.45(a) of title 42, Code of Federal Regulations)* of public funds as a source of State share of financial participation under title XIX of the Social Security Act, *except* as may be necessary to… deny Federal financial participation for public funds described in section 1903(w)(6)(A) of such Act (as added by section 2(a) of this Act) that are derived from

[9] Res-Care, Inc. v. U.S., 735 F.3d 1384, 1389 (2013) (internal quotations omitted).
[10] National Ass'n of Home Builders v. Defenders of Wildlife, 551 U.S. 644, 662 (2007) (internal quotations omitted).
[11] *Id.*
[12] H.R. 3595, Pub. Law. 102-234, 102nd Congress, at Section 5(a).

> donations or taxes that would not otherwise be recognized as the non-Federal share under section 1903(w) of such Act" (emphasis added).

By acknowledging CMS's regulation as a permissible interpretation of § 1902(a)(2), Congress expressly endorsed a broad interpretation of the funds from local sources that may be used as State financial participation. In addition, the Conference Report that accompanied the Amendments notes that "current transfers from county or other local teaching hospitals *continue to be permissible* if not derived from sources of revenue prohibited under this Act.[13] Thus, the plain language of the Amendments as well as the related legislative history evidence Congress's unambiguous intent that "funds from local sources" is broad enough to include funds generated through the operations of a local governmental entity, including a local governmental health care provider.

In summation, the Tax Revenue Requirement entails an interpretation of § 1902(a)(2) that is inconsistent with the statute's plain meaning and design, as well as the legislative history of § 1903(w). Because the Tax Revenue Requirement cannot be reconciled with the remainder of Title XIX, it is not a permissible interpretation of the Act.

CMS Needs to Clarify the Meaning of "Unallowable Sources". Proposed § 433.51(b) allows certain funds to be transferred from units of government within a State "except as provided in paragraph (d) of this section." Section 433.51(d) states that IGTs "that are contingent upon the receipt of funds by, or are actually replaced in the accounts of, the transferring unit of government from funds from unallowable sources, would be considered to be a provider-related donation that is non-bona fide under §§ 433.52 and 433.54." LeadingAge Wyoming requests that CMS revise proposed § 433.51(d) in order to serve CMS's stated intent to "more clearly define the allowable sources of the non-Federal share and more closely align the provisions of § 433.51 with the provisions of § 1903(w) of the Act."

The term "unallowable sources" in proposed § 433.51(d) is not defined in current or proposed regulations or used within § 1903(w) of the Act. The meaning of this term must be clarified in order to more clearly establish the funds that CMS intends to prohibit as State financial participation under proposed § 433.51(d).

CMS Should Revise § 433.51(d) in Order to Avoid Conflict with § 1903(w)(6)(B) of The Act. Section 1903(w)(6)(B) states that the "funds the use of which the Secretary may not restrict under subparagraph (A) *shall not* be considered to be a provider-related donation or a health care related tax."[14] However, proposed § 433.51(d) states that an IGT of funds, derived from tax revenue, from a unit of local government to the State Medicaid agency *is* considered a (non-bona fide) provider related donation under certain conditions. This outcome is plainly contrary to clear

[13] H. Rept. 102-310, at p. 18 (emphasis added).
[14] Emphasis added.

statutory language at § 1903(w)(6)(B). Thus, proposed § 433.51(d) should be revised to ensure that CMS does not restrict States' use of funds in violation of clear statutory mandate.

CMS Must Consult with The States. As mentioned above, Section 1903(w) of the Act was adopted as part of the Amendments.[15] Section 5(c) of the Amendments requires that the Secretary "*shall* consult with the States before issuing *any* regulations" under the Amendments.[16] The Proposed Rule does not include any reference to or summary of consultation with the States regarding proposed changes at § 433.51. CMS must first follow the procedures required by law in issuing any regulations interpreting § 1903(w).

STATE PLAN REQUIREMENTS

CMS proposes a number of changes to its regulations at § 447.252 that are contrary to the plain language, structure, and design of Title XIX. In addition, the proposed transition period for currently approved supplemental payments fails to take into account the significant reliance interests of providers in States where supplemental payments constitute a meaningful portion of total Medicaid payments made to compensate providers for services furnished to Medicaid beneficiaries.

CMS Needs to Address Whether Requiring The Total Amount of Supplemental Payments to Be Stated in The SPA Will Cap Available FFP. Proposed § 447.252(d)(3)(i) would require that any State plan amendment providing for a supplemental payment must specify "the amount of the supplemental payment made to each eligible provider, if known, or, if the total amount is distributed using a formula based on data from one or more fiscal years, the total amount of the supplemental payments for the fiscal year or years available to all providers eligible to receive a supplemental payment" (the "Total Expenditure Rule"). Because FFP is available only for a State's expenditures made in accordance with the terms of its State plan,[17] the Total Expenditure Rule would appear to cap the amount of expenditures eligible for FFP under the SPA at the specific dollar amount stated within the terms of the SPA at the time of approval. Beaver Valley Hospital requests that CMS clarify whether FFP would be available for any amount of supplemental payments paid by a State in accordance with the methodology set forth in the SPA but in excess of the total amount stated as being available to all eligible providers.

If The Total Expenditure Rule Would Effectively Cap The Amount of Expenditures Eligible for FFP, The Total Expenditure Rule is *Ultra Vires*. "A reasonable statutory interpretation must account for both the specific context in which language is used and the boarder

[15] H.R. 3595, Pub. Law. 102-234, 102nd Congress.
[16] Emphasis added.
[17] *See* 42 CFR §§ 430.10 (providing that the State plan is a "comprehensive written statement… contain[ing] all information necessary… to serve as a basis for [FFP]"), § 430.35 (providing for withholding of FFP due to "an unapproved change in the approved State plan"); § 447.304 ("FFP is not available for a State's expenditures for services that are in excess of the amounts allowable under this subpart.").

context of the status as a whole."[18] As discussed below, the statutory provisions and legislative history of Title XIX do not support capping FFP for supplemental payments.

States participate in the Medicaid program by submitting a State plan or plan amendment to CMS for approval.[19] Section 1902(b) provides that CMS "shall approve" State plan material that meets the requirements of § 1902(a).[20] Once approved, CMS "shall pay" to the State a specified proportion of the total amount expended by the State in accordance with its approved State plan.[21] The plain language of § 1903 requires FFP to be paid for eligible expenditures without limit.

The absence of a limit to the FFP available for Medicaid expenditures was a central feature of Title XIX when adopted by Congress as part of the Social Security Amendments of 1965 (the "Amendments of 1965"). A summary of the bill that became the Amendments of 1965 discussed that "[t]he Federal share of medical assistance expenditures under the new program [Title XIX] is determined by a uniform formula, with no maximum on the amount of expenditures subject to participation – the procedure followed for medical assistance for the aged."[22] The legislative history of the Amendments of 1965 evidences Congress's specific intent that there be no cap on Federal financial participation towards eligible Medicaid expenditures.

Since the adoption of Title XIX, proposals to impose a cap on Federal Medicaid expenditures have been raised periodically. For example, in the early 1980s, the Reagan administration proposed enactment of legislation to limit, or cap, Federal Medicaid expenditures.[23] Congress did not accept the administration's plan.[24] A bill introduced in 2017 proposed to establish a per-capita limit on the amount of FFP that the Federal government would contribute towards State Medicaid program expenditures.[25] The bill was not enacted. The Trump administration also proposed as part of its Fiscal Year 2020 Budget to implement comprehensive Medicaid financing reform through a per capita cap or block grant.[26] However, CMS withdrew proposed guidance on block grants and per capita cap programs in January 2020.

"When an agency claims to discover in a long-extant statute an unheralded power" to accomplish an objective that for over 30 years was thought to require legislative amendment, a Court can be expected to "greet its announcement with a measure of skepticism."[27] The Total

[18] Utility Air Regulatory Group v. E.P.A., 573 U.S. 302, 321 (2014) (internal quotation marks omitted).
[19] *See* Social Security Act §§ 1116(a) and (b).
[20] Social Security Act § 1902(b).
[21] *See* Social Security Act § 1903(a).
[22] Social Security Amendments of 1965: Summary and Legislative History (Sept. 1965), at p. 17 (included as part of Social Security Amendments of 1965, Volume 5, at p. 346).
[23] Information Paper Prepared by the Special Committee on Aging, U.S. Senate, regarding Omnibus Budget Reconciliation Act of 1981, Public Law 97-35 (Sept. 1981), at PDF p 13-14.
[24] *See, e.g.*, Information Paper Prepared by The Special Committee On Aging, U.S. Senate, *re:* Omnibus Budget Reconciliation Act of 1981, Pub. Law 97-35 (Sept. 1981), at p. 9.
[25] H. R. 1628 – American Health Care Act of 2017, 115th Congress (2017-2018), at Section 121.
[26] Fiscal Year 2020 Budget of the U.S. Government, at p. 43.
[27] Utility Air Regulatory Group v. E.P.A., 573 U.S. 302, 324 (2014).

Expenditure Limit is an unreasonable interpretation of CMS's authority at § 1902(a)(30) because the Expenditure Limit is inconsistent with clear and coherent statutory language and legislative history. Agency discretion involves "[choosing] among competing reasonable interpretations of a statute; it does not license interpretive gerrymanders under which an agency keeps parts of statutory context it likes while throwing away parts it does not."[28]

CMS Does Not Have Authority To "Expire" Approved State Plan Material or Impose A Limited Approval Period for New State Plan Material. Proposed § 447.252(e) would cause the "State plan authority" for supplemental payments that are part of State plan material approved 3 or more years ago to "expire" 2 years following the effective date of the final rule, if any (the "Sunset Rule"). CMS describes the Sunset Rule as a "transition plan" for States with currently approved SPAs to come into compliance with proposed §§ 447.252(d) and (d)(4), which would limit CMS approval of supplemental payments to a period of no more than 3 years (the "Limited Approval Rule"). For the reasons discussed below, CMS does not have the authority to adopt the Sunset Rule or the Limited Approval Rule.

The Sunset Rule and Limited Approval Rule are contrary to the statutory language and structure of Title XIX. Whenever possible, a statute must be interpreted "as a symmetrical and coherent regulatory scheme," with all parts forming a "harmonious whole."[29] In the sequential statutory sections of §§ 1902, 1903, and 1904, Congress set forth, respectively: (a) the requirements for a State plan to be approved by CMS; (b) the Federal government's obligation to pay FFP for expenditures under an approved State plan; and (c) the "sole remedy" of withholding FFP in the event of a State's noncompliance with Medicaid program requirements. The plain language of these statutory provisions as well as their relationship to one another compel the conclusion Title XIX simply does not contemplate the expiration or termination of CMS's approval of State plan material.

States participate in the Medicaid program by submitting a State plan to CMS for approval.[30] A State must also submit any amendments to its State plan "that it may make from time to time."[31] Section 1902(b) provides that CMS "shall approve" State plan material that meets the requirements of § 1902(a).[32] Once approved, CMS "shall pay" to the State a specified proportion of the total amount expended by the State in accordance with its approved State plan.[33] When Congress uses the word "shall," it imposes "discretionless obligations."[34]

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[28] Michigan v. E.P.A., 135 S.Ct. 2699, 2708 (2015).
[29] *See* Food & Drug Admin. v. Brown & Williamson Tobacco Corp., 529 U.S. 120, 133 (2000) (quoting Gustafson v. Alloyd Co., 513 U.S. 561, 569 (1995) and FTC v. Mandel Brothers, Inc. 359 U.S. 385, 389 (1959)).
[30] *See* Social Security Act § 1116(a).
[31] Douglas v. Independent Living Center of Southern California, Inc., 132 S.Ct. 1204, 1205 (2012) (recognizing a State plan as ongoing); *see also*, Social Security Act § 1116(b); 42 CFR § 430.12(c) (requiring plan amendments whenever necessary to reflect changes in law).
[32] Social Security Act § 1902(b).
[33] *See* Social Security Act § 1903(a).
[34] Lopez v. Davis, 531 U.S. 230, 231 (2001); *see also*, National Ass'n of Home Builders v. Defenders of Wildlife, 551 U.S. 644, 661 (2007).

The absence of language authorizing CMS to limit or qualify its approval of State plan material under § 1902 is consistent with the ongoing obligation under § 1903 to pay FFP for eligible expenditures.

The express language of § 1902(b), which allows CMS no discretion to limit or condition its approval of State plan material, is also consistent with the "sole remedy"[35] that Congress provided for a State's failure to comply with Medicaid program requirements. If CMS finds that the provisions of an approved State plan or a State's administration of its approved State plan fail to comply with the applicable requirements of § 1902, § 1904 states that CMS may, after giving reasonable notice and an opportunity for hearing, withhold further FFP to the State "*until* [CMS] is satisfied that there will no longer be any such failure to comply."[36] Giving meaning to Congress' use of the word "until," § 1904 indicates that the provisions of a State plan remain in effect and resume as a basis for FFP as soon as the provisions are administered in compliance with applicable requirements or amended to comply with new requirements.[37] Thus, even in the context of specific findings of non-compliance, Congress did not expressly or impliedly provide for the termination or expiration of State plan material.

If Congress had wanted the approval of State plan material to expire or terminate, "it knew how to use those words and could have done so."[38] For example, under § 1115(a), which provides the statutory authority for States to undertake "experimental, pilot, or demonstration project[s]" through their Medicaid program, CMS is authorized to waive compliance with any of the requirements of §§ 1902 and 1903 "*for the period* he finds necessary…."[39] Under § 1915, Congress authorized CMS to grant various waivers of Medicaid requirements for the particular periods of time set out in statute.[40] Congress also provided that CMS may "terminate any such waiver where [CMS] finds that noncompliance has occurred."[41] On the other hand, in the provisions of § 1915 that provide for coverage of certain non-traditional Medicaid services as a formal State plan option (*i.e.*, through a State plan amendment),[42] there is a notable absence of any language indicating approval for only so long or at CMS discretion to terminate.[43] Thus, when

[35] Armstrong et al. v. Exceptional Child Center, Inc., et al., 135 S.Ct. 1378, 1385 (2015) ("The sole remedy Congress provided for a State's failure to comply with Medicaid's requirements… is the withholding of Medicaid funds by [CMS].").
[36] Social Security Act § 1904; *see also*, 42 CFR § 430.35.
[37] *See also*, HCFA, 66 Fed. Reg. 3147, 3163 (Mar. 13, 2001) (Final Rule) (indicating that FFP will be disallowed unless States submit conforming State plan amendments).
[38] Res-Care, Inc. v. U.S., 735 F.3d 1384, 1389 (2013).
[39] Social Security Act § 1115(a).
[40] *See* Social Security Act § 1915(b), (c)(3), (d)(3), (e)(3), and (h).
[41] Social Security Act § 1915(f).
[42] *See* Social Security Act § 1915(i)(1), (k)(1) ("a State may provide through a State plan amendment….").
[43] If a State elects to target the services to a specific population and to differ the type, amount, duration, or scope of the services to such specific populations, the State's election "shall be for a period of 5 years." Social Security Act § 1915(i)(7)(B). This period of approval relates only to the election to provide the home and community-based services to specific, targeted populations; its expiration would not expire the underlying State plan amendment pursuant to which home and community-based services are furnished in the first place.

Title XIX provides for CMS approval that is bounded or subject to termination, it does so expressly.[44]

"Where Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposefully in the disparate inclusion or exclusion."[45] As the Supreme Court reasoned in *Department of Homeland Security v. MacLean*,[46] this interpretive canon applies with "particular force" where the inclusion or exclusion is used repeatedly. Under Title XIX, Congress repeatedly omits any reference to a limited period of effectiveness with respect to CMS approval of State plan material. On the other hand, Congress repeatedly includes reference to a limited term of effectiveness for CMS approvals related to waivers or expenditure authority separate from a State plan. This comparison makes Congress's choice to omit such limitations in connection with CMS approval of State plan material seem "quite deliberate."[47]

"[I]t is well established that an agency may not circumvent specific statutory limits on its actions by relying on separate, general rulemaking authority."[48] An "administrative agency [is] bound, not only by the ultimate purposes Congress has selected, but by the means it has deemed appropriate, and prescribed, for the pursuit of those purposes."[49] The statutory context of Title XIX evidences Congress's clear intent that CMS does not have the authority to expire approved State plan material or impose a limited approval period on new State plan material.

The Sunset Rule and Limited Approval Rule Exceed the Meaning That Section 1902(a)(4)(A) Can Bear. CMS presents the Sunset Rule and Limited Approval Rule as an exercise of its authority under § 1902(a)(4)(A) to require that a State plan must "provide… such methods of administration… as are found by the Secretary to be necessary for the proper and efficient operation of the plan…." This explanation indicates that CMS views these proposed changes as a method of "administration." The word "administration" is defined in the Merriam-Webster dictionary as "the *performance* of executive duties" and "the *act or process* of administering something."[50] Contrary to these meanings, both the Sunset Rule and the Limited Approval Rule operate only to *cease* the performance or process of a State's duties under State plan material. Although § 1902(a)(4) of the Act confers broad discretionary authority, CMS cannot avoid its obligation to implement such authority consistent with the plain meaning of its terms and "in a manner that is [consistent] with the administrative structure that Congress enacted into law."[51]

[44] *Accord*, Sebelius v. Cloer, 569 U.S. 369, 378 (2013).
[45] Sebelius v. Cloer, 569 U.S. 369, 378 (2013).
[46] Dep't of Homeland Sec. v. MacLean, 135 S.Ct. 913, 919 (2015).
[47] *See* Dep't of Homeland Sec. v. MacLean, 135 S.Ct. 913, 919 (2015).
[48] Air Alliance Houston v. E.P.A., 906 F.3d 1049, 1061 (2018).
[49] MCI Telecomm. Corp. v. American Tel. & Tel. Co., 512 U.S. 218, 230 (1994) (at fn. 4).
[50] Emphasis added.
[51] Food & Drug Admin. v. Brown & Williamson Tobacco Corp., 529 U.S. 120, 121 (2000).

In addition, whether the Sunset Rule and Limited Approval Rule are consistent with CMS's authority under § 1902(a)(4)(A) must be "guided to a degree by common sense as to the manner in which Congress is likely to delegate a policy decision of such economic and political magnitude to an administrative agency."[52] CMS reports in the Proposed Rule that non-DSH supplemental payments accounted for $16.4 billion in FY 2016. The Congressional Research Service reported that non-DSH supplemental payments in FY 2017 were $24.6 billion, or 4.3% of total Medicaid medical assistance expenditures.[53] In roughly six states, however, non-DSH supplemental payments represented over 10% of total Medicaid medical assistance expenditures during FY 2017, including as much as 15% of total expenditures in one state.[54] The Sunset Rule would summarily end the payment of FFP towards these expenditures without so much as a single finding of noncompliance. Certainly, "Congress could not have intended to delegate a decision of such economic and political significance to an agency in so cryptic a fashion"[55] as § 1902(a)(4)(A).

The Sunset Rule Is An Invalid Attempt to Promulgate A Retroactive Rule. Even if, *arguendo*, CMS has the authority to adopt the Limited Approval Rule, CMS may not retroactively impose such requirements on or read such requirements into already approved State plan material. "[A] statutory grant of legislative rulemaking authority will not, as a general matter, be understood to encompass the power to promulgate retroactive rules unless that power is conveyed by Congress in express terms."[56] In *Bowen v. Georgetown University Hospital*, the U.S. Supreme Court found that the statutory provisions establishing CMS's general rulemaking power contain no express authorization of retroactive rulemaking and that there is no reason to believe that Congress intended to provide CMS with such authority.[57]

CMS's past administrative practice also supports the finding that it lacks authority to apply its regulations retroactively.[58] In response to criticism from the GAO in 2001 about CMS approving SPAs for upper payment limit programs that would have been prohibited according to regulations that were adopted while those SPAs were pending approval, CMS stated:

> "CMS reviews state plan amendments under the law on the effective date of the plan amendment. For pending amendments, the proposed effective date is generally the first day of the calendar quarter of submission…. The [HHS] General Counsel opined that [CMS] was prohibited from denying these payments under *Bowen v. Georgetown*; the [APA] precludes rules such as the UPL regulation from being given retroactive effect."[59]

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[52] *Id*.
[53] Congressional Research Service, Medicaid Supplemental Payments (updated Dec. 7, 2018), p. 8, *available at:* https://fas.org/sgp/crs/misc/R45432.pdf.
[54] *See id*., at p. 9.
[55] Food & Drug Admin. v. Brown & Williamson Tobacco Corp., 529 U.S. 120, 121 (2000).
[56] Bowen v. Georgetown Univ. Hosp., 488 U.S. 204, 208-9 (1988).
[57] *Id*.
[58] *Id*.
[59] CMS comments to GAO Report to Congressional Requesters (Oct. 2001).

Because CMS does not have the authority to promulgate retroactive rules, CMS does not have the authority to adopt the Sunset Rule.

The Proposed Transition Period Should Be Longer for States With Supplemental Payments Approved 3 or More Years Ago. Consistent with its past administrative practice,[60] CMS should recognize that providers in States with supplemental payment programs approved 3 or more years ago have a greater reliance interest in those payments than providers in States with supplemental payment programs approved less than 3 years ago. Accordingly, CMS should provide a longer transition period for supplemental payments approved 3 or more years ago versus supplemental payments approved more recently.

CMS Needs to Clarify How Proposed Requirements Would Apply to Approved Supplemental Payments during The Transition Period. CMS describes the Sunset Rule as a "transition plan" for States with currently approved SPAs to come into compliance with the Limited Approval Period. However, CMS also states that the other proposed changes, such as the Tax Revenue Requirement and NSGO Definition, will be applied to current state plan provisions immediately. Given the significant differences between current CMS regulations and those set forth in the Proposed Rule, CMS needs to clarify how such changes will or will not apply to supplemental payments paid under currently-approved State plan material. CMS should ensure that any new requirements that it will apply to currently-approved State plan material will not compromise States' ability to provide supplemental payments during the transition period.

DEFINITIONS

CMS proposes to add at new § 447.286 definitions for several terms that are central to the changes that CMS seeks to adopt through the Proposed Rule. However, the proposed definitions for "non-State government provider," "base payment," and "supplemental payment" require substantial clarification. The proposed definition of non-State government provider, in particular, raises significant concerns in relation to the regulatory framework of Title XIX as a whole.

CMS Needs to Clarify How It Would Reconcile The Non-State Government Provider Definition With Other Statutory and Regulatory Requirements. CMS proposes to adopt new definitions for the facilities that fall within each of the three categories for which CMS regulations calculate an aggregate UPL. CMS proposes to define "Non-State government provider" as a health care provider, as defined in § 433.52, that is a unit of local government in a state, including a city, county, special purpose district, or other governmental unit in the state that is not the state, "which has access to and exercises administrative control over state funds appropriated to it by the legislature or local tax revenue, including the ability to dispense such funds" (the "NSGO Definition"). CMS would have the authority to determine whether a provider fits the NSGO Definition based on CMS's consideration of "the totality of the circumstances."

[60] *See, e.g.*, HCFA, Medicaid Program; Revision to Medicaid Upper Payment Limit Requirements, 66 Fed. Reg. 3147, 3160-3161 (Jan. 12, 2001) (Final Rule).

CMS's explanation for proposing the NSGO Definition suggests that CMS is primarily interested in applying a "totality of the circumstances" test to challenge whether the licensed operator of a facility is, in fact, the "actual owner." A finding that a particular facility is operated by an entity other than the entity that is licensed and certified to provide nursing facility services at the facility location would have far-reaching implications for the facility's and State's compliance under both Federal and State laws (as further discussed below). CMS needs to address how it would reconcile such issues.

The NSGO Definition Is Internally Contradictory and Conflicts with Foundational Statutory Requirements of Title XIX. CMS proposes to apply a "totality of the circumstances" test to a determination of whether a particular "health care provider, as defined in § 433.52" is a governmental entity. Section § 433.52 defines a health care provider as "the individual or entity that receives any payment or payments for health care items or services provided."[61] The individual or entity that owns the bank account where payments are deposited is an unambiguous fact established during the Medicaid enrollment process. Thus, the definition of a health care provider at § 433.52 is wholly incompatible with the concept of a totality of the circumstances test, because a determination that *some other* individual or entity is the "true" health care provider directly conflicts with the defined meaning of this term.

Even more untenable, the NSGO Definition would allow CMS to make determinations that conflict with foundational statutory requirements of Title XIX. For example, the Act allows payment for Medicaid services to be made only to the individual or institution that provided the care or service.[62] Before a provider can be paid for Medicaid services, the Act requires that the provider must disclose certain ownership information[63] and enter into a provider agreement with the State.[64] The Act also requires, for a provider such as a nursing facility, that the provider must be licensed to provide such services. The NSGO Definition would allow CMS to determine that an entity other than the licensed entity from whom the State has obtained the required ownership disclosures, with whom the State has entered into a provider agreement, and to whom the State issues Medicaid payments is the true health care provider.

Additionally, the NSGO Definition makes it impossible for a State to ensure compliance with the Act's requirements for public process regarding the State's payment methodologies for nursing facility services.[65] Wyoming and many other states have adopted payment methodologies for nursing facility services that apply differently according to the particular nursing facility's status as State owned, non-State government owned, or private. The NSGO Definition would allow CMS to make a determination that affects the methodologies governing a particular nursing facility's Medicaid payments based on an ad hoc assessment by CMS of the nursing facility's business relationships at a particular point in time. In this way, the NSGO Definition inhibits fair

[61] 42 CFR § 433.52.
[62] Social Security Act § 1902(a)(32).
[63] Social Security Act § 1902(kk).
[64] Social Security Act § 1902(a)(27).
[65] Social Security Act § 1902(a)(13).

notice of the payment rates applicable to a nursing facility and leaves no opportunity for a nursing facility to comment or appeal.

"A reviewing court must reject administrative constructions of a statute, whether reached by adjudication or by rulemaking, that are inconsistent with the statutory mandate or that frustrate the policy that Congress sought to implement."[66] In *Food and Drug Admin. V. Brown & Williamson Tobacco Corp.*, the U.S. Supreme Court detailed the numerous contradictions that would arise as a result of the FDA's interpretation of its regulatory authority and found it therefore "inescapable" that there is "no room" for that interpretation within the Food Drug & Cosmetic Act's regulatory framework.[67] By the same reasoning, it is equally inescapable that the NSGO Definition has no place within the framework of Title XIX and is, therefore, *ultra vires*.

The NSGO Definition Exceeds Any Permissible Interpretation of § 1902(a)(30)(A). CMS presents the NSGO Definition as an exercise of its authority under § 1902(a)(30)(A) to require that a State plan must "provide such methods and procedures relating to… payment for, care and services available under the plan… as may be necessary to… assure that payments are consistent with efficiency, economy, and quality of care." In other words, CMS proposes the NSGO Definition as among the "methods and procedures" permitted under § 1902(a)(30)(A). Certainly, the common meanings of these terms allow CMS considerable flexibility. However, the meaning – or ambiguity – of the "methods and procedures" that may be implemented under § 1902(a)(30)(A) is further clarified by consideration of their place in the overall statutory scheme.[68]

A fundamental element of Title XIX is to provide States with flexibility in how they design their respective Medicaid programs. Within the guidelines set forth under § 1902, each State determines the design of its program, eligible groups, benefit packages, payment levels for coverage and administrative and operating procedures. While this context does not make clear what the "methods and procedures" required by § 1902(a)(30)(A) are, it does make clear what such "methods and procedures" are *not*:[69] they are not methods or procedures intended for *CMS* to follow. Thus, the NSGO Definition is manifestly inconsistent with the authority it purports to interpret.

CMS Needs to Clarify The Difference Between "Supplemental Payments" and "Base Payments". The proposed definitions for "supplemental payment" and "base payment" are unclear both with respect to their mutual distinction as well as their application to Medicaid payment methodologies. First, both "supplemental payment" and "base payment" are defined as being not the other: a base payment means "a payment, *other than a supplemental payment*…," and a supplemental payment "means a Medicaid payment to a provider *that is in addition to* the

[66] Securities Industry Ass'n v. Board of Governors of the Fed. Reserve Sys., 468 U.S. 137, 143 (1984) (internal quotations omitted).
[67] Food & Drug Admin. V. Brown & Williamson Tobacco Corp., 529 U.S. 120, 143 (2000).
[68] *See* King v. Burwell, 135 U.S. 2480, 2483 (2015) ("[W]hen deciding whether the [statutory] language is plain, the Court must read the words 'in their context and with a view to their place in the overall statutory scheme.'"), quoting Food and Drug Admin. V. Brown & Williamson Tobacco Corp., 529 U.S. 120 (2000).
[69] *Accord*, American Hospital Association v. Azar, ---F.Supp.3d --- (2019).

base payments to the provider…." By each definition containing a reference to the other, the proposed definitions result in a circular reference that is unworkable.

CMS also needs to clarify when a payment "can be attributed to a particular service," as in the case of a base payment, versus when a payment "cannot be attributed to a particular provider claim for specific services," as in the case of a supplemental payment. For example, non-State government owned ("NSGO") nursing facilities in Wyoming are eligible to receive additional payments based on actual paid nursing facility claims adjusted to the amount the facility would have been paid for those claims under Medicare payment principles. The additional payments made to NSGO facilities are based on the specific Medicaid services furnished by the facility and the particular acuities of the beneficiaries who received the services. LeadingAge Wyoming requests that CMS clarify that such payments satisfy the required elements of a base payment.

REPORTING REQUIREMENTS FOR UPL DEMONSTRATIONS AND SUPPLEMENTAL PAYMENTS

CMS proposes to adopt new regulations at § 447.288 which require states to submit a UPL Demonstration as part of a SPA that provides for supplemental payments by October 1st of each year. The Proposed Rule would allow states to demonstrate compliance with applicable UPLs using a payment-based or cost-based method (the "UPL Demonstration Methods").

CMS Must Correct Nursing Facility UPL Demonstration Standards. The UPL Demonstration Standards appear to contain a number of errors. For example, a state would be required to demonstrate compliance with the UPL for each category of nursing facilities using either Medicare cost and charge data or Medicare payment and charge data and calculate the applicable UPL based on a formula that includes a cost-to-charge ratio or payment-to-charge ratio. While CMS presents the UPL Demonstration Standards as a codification of existing policy, the UPL Demonstration Standards do not reflect how UPL is calculated for nursing facilities under current policy. Moreover, contrary to current and proposed regulation at § 447.272(b), the UPL Demonstration Standards as applied to nursing facilities do not reflect Medicare payment principles for nursing facilities under 42 CFR Chapter IV, Subchapter B.

FAILURE TO REPORT REQUIRED INFORMATION

CMS proposes to adopt a new regulation at § 447.290 allowing CMS to defer FFP in accordance with § 430.40 by the amount CMS estimates is "attributable to payments made to the provider or providers as to which the State has not reported properly, until such time as the State complies with the reporting requirements" of proposed § 447.288.

CMS Needs to Clarify How It Will Evaluate Compliance with Proposed Supplemental Payment Reporting Requirements at § 447.288(c) Regarding Provider-Specific Information Relative to the NSGO Definition. CMS proposes to withhold FFP from a State that does not completely and accurate report the information required at proposed § 447.288. This information includes, inter alia, the "provider category" (*i.e.*, State government, non-State government, or private). However, the NSGO Definition sets forth a totality of the circumstances test by which CMS determines whether a provider is a non-State government provider. CMS needs to clarify how it intends to hold States accountable for the accuracy of a determination that only CMS has the authority to make, at no specifically defined time, based on a discretionary set of considerations.